

DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

PRINTED: 05/19/2014
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155064		(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED C 05/15/2014	
NAME OF PROVIDER OR SUPPLIER FAIRMONT REHABILITATION CENTER LLC				STREET ADDRESS, CITY, STATE, ZIP CODE 3518 S LAFOUNTAIN ST KOKOMO, IN 46902			
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)			ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)		(X5) COMPLETION DATE
F 000	<p>INITIAL COMMENTS</p> <p>This visit was for the Investigation of Complaints #IN00148222, #IN00148565, and #IN00148718.</p> <p>Complaint #IN00148222- Substantiated. No deficiencies related to the allegation are cited. Complaint #IN00148565- Unsubstantiated due to lack of evidence Complaint #IN00148718- Substantiated. No deficiencies related to the allegation are cited.</p> <p>Survey dates: May 13, 14, & 15, 2014</p> <p>Facility number: 000025 Provider number: 155064 AIM number: 100274850</p> <p>Survey team: Michelle Carter, RN Tammy Alley RN (May 13, 2014)</p> <p>Census bed type: SNF- 10 SNF/NF- 53 Total- 63</p> <p>Census payor type: Medicare- 22 Medicaid- 29 Other- 12 Total- 63</p> <p>Sample: 5</p> <p>Fairmont Rehabilitation Center was found to be in compliance with 42 CFR Part 483, Subpart B and</p>			F 000			

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE

TITLE

(X6) DATE

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

PRINTED: 05/19/2014
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155064	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED C 05/15/2014
NAME OF PROVIDER OR SUPPLIER FAIRMONT REHABILITATION CENTER LLC			STREET ADDRESS, CITY, STATE, ZIP CODE 3518 S LAFOUNTAIN ST KOKOMO, IN 46902		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE	
F 000	Continued From page 1 410 IAC 16.2 in regard to the Investigation of Complaints #IN00148222, #IN00148565, and #IN00148718. Quality Review 05/16/14 by Lisa McColly	F 000			